Influencing Commissioning in New South Wales

Facilitator manual

About

Audience

'Influencing Commissioning in New South Wales' is for anyone who has an interest in how services are planned and commissioned and how the public can be involved in this. It has been written for a mixed audience of both lay people and professionals.

How to use this resource

This document includes a framework of learning areas and learning outcomes designed to support people to get involved in influencing commissioning. This manual has been written so that no formal scientific training or expertise in commissioning is required to use it or deliver training.

Share and share alike

Everything in this manual is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License.

Some of the resources in this manual have been adapted from:

'Influencing Commissioning', created by Jack Nunn, Derek Stewart and Jamie Spencer for Macmillan Cancer Support and available under the same licence.

More information about that resource can be found here[1].

Some resources were created by Jack Nunn for the Health Issues Centre and have been adapted with their kind permission.

Acknowledgements

This manual was created by Jack Nunn for the Health Consumers NSW.

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Jacknunn.com

[1] http://learnzone.org.uk/courses/course.php?id=228

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About the course 'Influencing Commissioning in New South Wales'

This course is an introduction to how the public can influence commissioning decisions at a local and national level in Australia

Aim

To enable and empower the public to understand how to become effectively involved in the commissioning of health and social care services.

Outcomes

Participants will understand how to apply their knowledge and experience in a practical way to help improve how the public are involved in decision making in the commissioning cycle.

By the end of this course:

- Participants will be able to **explain what commissioning is**.
- Participants will be able to **explain the process called the 'commissioning cycle'** and summarise how it works
- Participants can explain the importance of partnership working between:
    - the public (patients, carers and health service consumers)
    - health and social care professionals
    - professionals involved in commissioning decisions.
- Participants can summarise the various ways of how the public can be actively and constructively involve the public at every stage of the commissioning process.
- People will be able to summarise the international and national context of commissioning and how this impacts at a local level.
- Participants will have experience of explaining key points to help others understand.

Because of the subject of this course an essential element of this course involves participants interacting during the day so that they can:

- meet new people, share knowledge and perspectives
- find and create opportunities to apply the learning from the day.

Timings

This workshop will be designed to run for 5 hours, with 1 hour for breaks.

Delivery

In order to achieve specific learning outcomes, this workshop will be delivered using a combination of:

- Pre-prepared learning resources
- Interactive activities
- Facilitated discussions

Where possible, each course will be tailored to the local context.

Learning resources

All the learning resources created for this course will be shared electronically with all participants after they have attended.

Course outline

(next page)

Session	Summary	Time (min)	Clock time start	Online interaction
Introductions	Introductions and expectations	**15**	10:00	• Introduce self and explain that we'll be running the course online too. • Start live broadcast • Invite online people to introduce themselves via chat and state what they'd like to get out of the session • Online participants listen to group feedback and facilitator to share expectations of online participants'
Why Care?	A chance to look at how commissioning fits into the bigger picture of everyone's health, happiness and human rights.	**25**	10:15	• Invite responses via discussion forum chat • Feedback any relevant points
What is the commissioning cycle?	To help define what is meant by the word 'commissioning' and where the public can be involved in the cycle.	**45**	10:40	• Ask questions in chat '"What factors determine what food you buy for next week's meals?" • Ask people to work through next activities independently offline (or stay online if you wish to chat to others) • Prepare for feedback later • Stop live broadcast
Break		**20**	11:25	Offline (chat only)
Whose money is it?	Exploring people's thinking about healthcare spending	**30**	11:45	
Data, evidence and involving the public in research	To explore the role the public can have in collecting data and analysing it to help make evidence-based decisions. *Note, this activity may be split over lunch*	**50**	12:15	
Lunch		**45**	1:05	

Who's who?	A summary of who has the money, who spends the money, who oversees the process and who acts on behalf of the patient and public.	**30**	1:50	
Break		**15**	2:20	
Online welcome back	Welcome back to online participants	**5**	2:35	• Start live broadcast • Ask for feedback on who's who once this is gathered from participants in the room – what is missing? (Check the grid in the google doc is filled in in the room and online)
Pass it on	An opportunity to make an action plan about next steps and to think about how to help others learn about commissioning.	**30**	2:40	• Invite anyone online to share anything they learned and any actions • Thank people online and close online session. • Stop live broadcast • Continue activity with people in the room
Close	Summary and feedback	**15**	**3:10**	Offline
Finish (leaving 30 minutes spare if more time is required for activities or breaks)			**3:30**	

Detailed facilitation plan

Preparation

Printing

Resource	Number
Resource 1: A brief history of human rights in healthcare	1 between 2
Resource 2: Why and how: Involving the public in the commissioning cycle	Library table
Resource 3: Existence	
Resource 4: What affects individual experience?	1 each
Resource 5: What is data?	Library table
Resource 6: How data becomes evidence that shapes services	
Resource 7: Leading underlying causes of death in Australia by age group, 2012–2014	1 between 2
Resource 8: Data – understanding and visualisation	1 between 4
Resource 9: Recurrent health expenditure, by source of funds and area of expenditure, 2013-14	1 between 4 (print back to back with Resource 10)
Resource 10: Patient Experience Survey 2013-14 (selected results)	
Resource 11: Data - Perceptions and reality – matching drugs with deaths	1 between 3
Resource 12: Statistics – state data and community data	1 between 3
Resource 13: Language to describe commissioning Resource 14: The commissioning cycle	Library table
Resource 15: Levels of involvement	
Resource 16: What Are You Doing To Involve People?	1 each (print back to back with resource 17)

Resource 17: Assessing: how are the public involved?	
Resource 18: Diagram of engagement, participation and involvement in commissioning	1 between 4 (print back to back with resource 19)
Resource 19: Answering important questions using Maslow's 'hierarchy of needs'	
Resource 20: Patient, consumer and public involvement	Library table
Resource 21: Who's who?	1 between 3 (A3 if possible)
Resource 22: Who I met	1 each
Resource 25: Action plan	1 each (Print back to back with Resource 26)
Resource 26: Skills and knowledge grid	
Resource 27: Feedback Form	1 each
Additional resources	Library table

For the library table, usually 2-3 copies are sufficient. If it is a long document (more than 5 pages) printing certain pages or sharing the link with people is more appropriate.

Other preparation

In addition to printing the following needs to be prepared:

- Cut out the definitions and terms from Resource 13: Language to describe commissioning
- Cut out the dollars from Resource 23: 26 Billion dollars
- Draw out a flip chart with the following columns:

Prevention	Age	Reaction
	1. Prenatal 2. 0-14 3. 15-24 4. 25-44 5. 45-65 6. 65-74 7. 75-84 8. 85-94 9. 95+	

- Cut out scenarios from Resource 24: You decide: Scenarios

On the day

At the venue

On arrival at the venue you should check the following things. Please note that you should arrive at least 1 hour before the start of the session to allow time:

Safety and domestics – Find out where the fire exits are and if there are any planned fire drills or alarms. Locate the toilets and any disabled access toilets. Is there any food or tea and coffee? What time is this arriving? How is the temperature of the room controlled?

Welcome and signs - Is the room signed and easy to find? Does reception know the plans? Is anyone able to welcome and direct people?

The room

It is very important that you take charge of how the room is set out, remember, it is your session and you need to be as comfortable with it as much as the participants do.

The configuration of chairs can really affect the group dynamic. You may want to experiment until you find the seating that suits you best but remember that you will require delegates to write and work together and some may wish to take regular notes through the day so table or writing space may still be necessary. With all configurations it's important that everyone can see you, no delegates are hidden behind others and that each feels you can communicate with them both verbally and with eye contact. Sessions held on long boardroom style tables are the most difficult to work with and should be avoided when possible.

Ensure that anyone with sight or hearing problems is seated appropriately.

Ensure that the room is welcoming and tidy by making and food and drink accessible, drawing blinds to let light in, opening windows if it's stuffy.

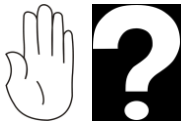
Consider writing a welcome note, the name of the course and your name in a visible place.

<u>As participants arrive</u>

- Welcome people as they arrive, introduce yourself (and if necessary your co-facilitator) and thank them for coming. Agendas normally allow 30 min for arrival and settling in.
- Ask people to sign in or tick them off as they arrive. **The list of delegates must stay with you all day for reasons of fire safety.**
- Leave the broad introduction until all are present or until the scheduled start time.

<u>Ready to start?</u>

- Welcome people and thank them for coming and give a brief introduction about the day.
- Get people to say their names, what they'd like to learn or gain from the training.
- If appropriate, ask them to include any experience of an illness they want to share or what motivated them to come to the day.
- Write what people want to learn (on a flip chart or something similar) and return to this at the end of the day to confirm people learned what they expected.
- If someone says something that will not be covered in the session, don't write it down and mention it won't be included
- Clarify course content, format and mutual expectations of the day and ask if anyone has any anxieties about the day.
- Draw pictures of the words in **bold** to prompt a discussion and consensus about the following:



  - **Fire exit and alarms** – make sure people know about these
  - **Toilets** – do people know where they are?
  - **Clock** – agree times for lunch, breaks and finishing. Does anyone need to leave early (mention they'll need to fill in an evaluation form before they do).
  - **A sealed envelope** for a discussion on confidentiality
  - **Spelling tick** – all spelling is korrect
  - **Thermometer** – people should say if the environment of the room is uncomfortable
  - **TLAs** (with a line through it) – This stands for 'three letter acronyms'. Please try to avoid using any acronyms as they can alienate those who don't know them
  - **Hand-up** – mention that people should feel free to say anything at any point, but some people find this hard and if they prefer they can raise their hands to signal they want to speak
  - **Question mark** – Remind people there is no such thing as a stupid question. Ask if would people like to add anything else? More experienced facilitators may wish to open up the session by stating that the agenda is a guide only and if the group have specific areas they want to explore, which may not be on the agenda, then that will be accommodated during the day

During lunch

- Ensure that people know where food is and that everyone's preferences have been catered for.
- Talk to any participants who might need extra attention and encourage networking where necessary.
- Ask if anyone is leaving early

Close

- Collect feedback forms
- Expenses claim forms?
- Encourage participants to swap contact details (using the 'who I met' sheet)
- When leaving the venue, try to leave it as you found it.
- Ensure that relevant venue staff know you have left.
- Relax!

Example activity

Learning aims	**Learning outcomes**	**Time**
What is the aim of this activity	What will people be able to do after this activity	
Resources	What resources are required	Min
Activity instructions		
How will this activity be structured		
Key learning points		
What is the main message for people to take away		

Introductions

Learning aims	Learning outcomes	
To provide a general outline of course and to give participants chance to introduce themselves	Participants will be able to explain the purpose of the day	
Resources	Flip chart, pens.	**15**
Activity instructions		
• Introduction of self and Health Consumer NSW and PHN staff • Briefly summarise the agenda and ask everyone in the group to say their name and what they would like to get out of today. • Housekeeping (including timings of the day)		
Key learning points		
This time is for everyone, so we should all be involved in shaping it to meet our needs		

Why Care?

Learning aims	Learning outcomes	Time
To give participants a chance to look at how commissioning fits into the bigger picture of everyone's health, happiness and human rights	Participants can: Explain why they think that health and social care is important Explain the concept of human rights and summarise how this relates to commissioning Summarise what is meant by the social determinants of ill health	
Resources	Flip chart, pens, Resource 1: A brief history of human rights in healthcare, Resource 4: What affects individual experience ?	**25**

Activity instructions

Ask the following questions, being careful to use the exact wording:

- What is public health?
- Why do societies around the world have health and social care?
- Why does Australia have a publicly funded universal health care system?

Ask for feedback. Try and draw out phrases which appear in the universal declaration of the 1948 UN declaration of human rights:

'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services'[2]

Talk about language used (public/involvement) Ask:

- 'who pays for services and who are they for?' (The answer is everyone!)
- Why the public should be involved in shaping health and social services (people usually answer yes, as we all pay - but not always so be prepared!) **Mention social determinants of health.**

State: The WHO 1978 Declaration of Alma Ata stated that 'The people have the right and duty to participate individually and collectively in the planning and implementation of their health care'

Ask who has heard of and can explain: 'Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 2: Partnering with Consumers'[3]

'requires leaders of a health service organisation to implement systems to support partnering with patients, carers and other consumers'

Mention: the 'Strategic planning' phase of commissioning which includes undertaking a needs assessment.

Ask someone to define 'co-design' – Central and Eastern Sydney PHN (CESPHN) defines it as **'**designing and delivering services and systems in an equal and reciprocal relationship between professionals, people using services, their families and their community'[4]**Blurring boundaries:** public health, community services, environment or education – which category does this come under – does it impact primary care? Air pollution, Sex education, Alcohol addiction, Smoking cessation

Key learning points

- Human rights, social determinants of ill health and health inequalities goes beyond health and social care and community services.
- Commissioning and primary healthcare networks cannot solve all these problems, but should be informed by them all
- In order to meet the needs of the public, the public must be involved in shaping the future of health and social care

What is the commissioning cycle?

[2] http://web.archive.org/web/20170525071813/http://www.un.org/en/universal-declaration-human-rights/index.html
[3] https://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard2_Oct_2012_WEB.pdf
[4] https://www.cesphn.org.au:9001/document-categories/our-region/1270-commissioning-mental-health-services-a-practical-guide-to-co-design-august-2016

Learning aims	Learning outcomes	Time
To help define what is meant by the word 'commissioning' and to understand it in real terms.	• Be able to explain what is meant by 'commissioning' • Be able to summarise the meaning of the words and terms of each stage of the commissioning cycle. • Participants can summarise where the public can be involved at each stage.	
Resources	Resource 2: Why and how: Involving the public in the commissioning cycle, Resource 13: Language to describe commissioning, Resource 15: Levels of involvement	**45**

Activity instructions

Ask the question "What factors determine what food you buy for next week's meals?"

- Stimulating questions can include 'does it start with a list, the people who will be eating, deciding who will buy and cook, which shop (local?), bulk buying and planning ahead?'

Gather feedback from participants in small groups or as one large group if short of time.

- When typical answers such as 'what is in the cupboard' are given, begin to draw these points on flipchart paper in the order they take place in commissioning.
- Once answers have been gathered, make broad links made to the elements of Commissioning – i.e. Planning (seasonal changes?), Specifying (Evaluating (good quality, cost-effective?), Assessing Needs (who is involved in assessing?), Contracting (Who does the shopping?)
- Use prepared stages of the commissioning cycle on pieces of paper and get the group to put them in order.
- Work through Resource 13: Language to describe commissioning
- Ask people which stage the public can be involved in – the answer is every stage – we will continue to explore how.
- Cut out 'rationale' for involving people at each stage, ask people to read it out and ask for suggestions of involvement (then give Resource 2: Why and how: Involving the public in the commissioning cycle)
- Get people to match definitions and stand next to the stage that it takes place
- Talk about levels of involvement (Resource XX: Levels of involvement)

Note: Some language used in this resource is language used by commissioners and the language may be unfamiliar to most people. Make sure to link it to familiar terms from shopping.

Advanced: For more advanced groups consider asking for examples of where they have been involved in any of these stages. **Talk about 20mph example in UK.**

Key learning points

- Commissioning is quite simply what we do when we buy what we need
- We all have transferable skills/knowledge that can be applied and used in the commissioning cycle.
- The public has invaluable wisdom, experience, knowledge; in particular local needs and wants.
- The public can be involved in every stage of the commissioning cycle, influencing the local needs assessment.
- If groups of patients, carers and members of the public work together, their voice is stronger.

Whose money is it?

Learning aims	Learning outcomes	Time
To explore people's thinking about healthcare spending	Participants will be able to: • summarise how much is spent on the Medicare in Australia • explain the concept of competing priorities with finite resources	
Resources	Resource 23: 26 Billion dollars, Resource 7: Leading underlying causes of death in Australia by age group, 2012–2014	**30**

Activity instructions

Medicare expenditure is expected to reach nearly $24 billion in 2016/17[5]

In 2013-14, the combined total health expenditure of the Australian, State and Territory and local governments was….any guesses?

"$104.6 billion, representing 67.6 per cent of total health expenditure within Australia. The Australian Government accounted for the largest proportion of health care expenditure — $63.5 billion or 41.0 per cent. State and Territory, and local governments contributed $41.1 billion or 26.6 per cent. The remainder was paid by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurance providers"[6]

- Another source, also government states - $154.6 billion in 2013–14[7]

Total real annual recurrent health expenditure per person was… $6248 (government $4284 and non-government $1964)

- You have 24 billion dollars – where are you going to spend it? – lay out age range of:

Prevention	Age	Reaction	
	10. Prenatal 11. 0-14 12. 15-24 13. 25-44 14. 45-65 15. 65-74 16. 75-84 17. 85-94 18. 95+	75-84 had the highest average cost of hospitalisation with CVD ($10,750)	Helpful comments and questions can include asking about a growing population, increase in cancer diagnosis, increase in elderly population, etc. Stimulate by asking questions about investment in prevention or treatment or palliative care. Note to group – note represents £1billion!

Show people resources, would they change anything? The 4 most expensive disease groups are **chronic—cardiovascular diseases**, **oral health**, **mental disorders**, and **musculoskeletal**. This amount is conservative because not all health-care expenditure can be allocated by disease, particularly diseases predominantly managed in primary health care.[8]

Key learning points

Everyone has different opinions about priorities, but research provides an invaluable and (hopefully) objective way to help make informed decisions.

5 https://books.google.com.au/books?id=oiGnCgAAQBAJ&lpg=PP1&dq=In%20Search%20of%20the%20Perfect%20Health%20System&pg=PP1#v=onepage&q=$23.6&f=false

6 http://web.archive.org/web/20170606024721/http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/health/rogs-2016-volumee-sectore.pdf

7 http://web.archive.org/web/20170606075844/http://www.aihw.gov.au/publication-detail/?id=60129554398

8 http://web.archive.org/web/20170606033708/http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547726

Data, evidence and involving the public in research

Learning aims	Learning outcomes	Time
To explore the role the public can have in collecting data and analysing it to help make evidence-based decisions.	Be able to summarise how: • data is collected at a local level • the public can be involved in analysing evidence • how evidence-based decisions can be made	
Resources	Resource 11: Data - Perceptions and reality – matching drugs with deaths, Resource 31: PHN Snapshot, Resource 28: Effect of early, brief computerized interventions on risky alcohol and cannabis use among young people Resource 29: 12-step programs for reducing illicit drug use, Resource 12: Statistics – state data and community data	**50**

Activity instructions

Drugs: Ask people to name some drugs. Ask 'What is a drug?' It's '*any substance (other than food that provides nutritional support) that, when inhaled, injected, smoked, consumed, absorbed via a patch on the skin, or dissolved under the tongue causes a physiological change in the body*'[9]. **Ask what they think about drugs in their area.** Make no comment, listen only.

- Show people the Resource 11: Data - Perceptions and reality – matching drugs with deaths.
- Ask them to select which drugs they think caused the most hospitalisations. [Answers in order: 1.Methamphetamine 2.Synth. cannabis 3.Alcohol 4.MDMA/Ecstacy 5.Amphetamine 6.Cocaine 7.LSD 8.Cannabis 9.Magic mushrooms]
- Talk about research, data and evidence. Ask if people have heard of the Cochrane and the Campbell Collaboration. Ask people to read Campbell Collaboration plain English reviews.

Everyone's problem: Get people into groups and give them each a problem to try and solve (or ask people to mention problems they'd like to solve). Ask people to **form groups of three** and assume a role as either 'person affected', 'Chief of a service provider' or 'Member of independent consumer organisation' (making sure it's a different role from real life!) Use 'Resource 12: Statistics – state data and community data Problems: **Women Experiencing Perinatal Depression, high rates of diabetes, people experiencing severe mental illness are not well supported, there are no affordable childcare facilities in the area.** Mention some of these are inspired by current or recent tenders from Central and Eastern Sydney PHN (CESPHN)[10].

- Show resources on data visualisation for inspiration. Using the 'Resource 12: Statistics – state data and community data – discuss how you would gather data about that problem, analyse it and present findings and solutions.

Now ask each group to solve the problem (At every stage ask – how can the public, consumers or service users be involved?):

- What question are they asking?
- How will they get data?
- Who will they involve in designing the intervention?
- What is their intervention
- How will they know if it works? (what are the outcome measures – **who decides these**?)
- Who will be involved in analysing and presenting data?

Key learning points

The public can be involved at every stage of evidence-based decision making and evaluation

[9] https://en.wikipedia.org/wiki/Drug

[10] http://archive.is/2017.06.04-052754/https://www.tenderlink.com/cesphn/

Who's who?

Learning aims	Learning outcomes	Time
• Provide people with knowledge about the different people involved in commissioning. • Explore the existing knowledge that participants have particularly of the local organisations • To map out the relationship between the different roles	Be able to summarise who has the money, who spends the money, who oversees the process and who acts on behalf of the patient and public.	
Resources	Resource 21: Who's who ? Resource 22: Who I met, flipchart	**40**

Activity instructions

Get participants into groups and ask them to spend 10 minutes filling out the 'Resource 21: Who's who ??'. During the activity ask people to consider the following questions:

1. Who's got the money (from taxpayers)?
2. Who's spending it?

Once the groups have filled it out, ask each group in turn to mention one group they've added to the grid (go around until all are captured). Try to capture all of this on a flipchart.

When people feedback, ask if anyone in the group has ever met or talked to someone from that organisation (or is/has been part of it!)

Ask 'Was this a positive or negative experience?'

If time, encourage a group discussion about:

- the roles and relationships between organisations on the grid, as well as commenting on existing connections within the group.
- **Where do they go?** Discuss where some of them would fit on the commissioning cycle
- **Who can I work with?** Ask the group to identify people or organisations they could work with to influence commissioning. Where possible, try and use real people and contact details where appropriate.

Remind people about Resource 22: Who I met

Key learning points

Various individuals are and organisations are responsible for spending money. It is the public, patients and carers and consumers who have an invaluable insight into where it could be spent and how.

Pass it on

Learning aims	Learning outcomes	Time
To give an opportunity to make an action plan about next steps and to think about how to help others learn about commissioning.	• Participants can explain what next steps or actions they can take • Participants can summarise commissioning and explain where the public can get involved. • Participants can recognise barriers to explaining how the public can be involved and supporting others to being involved and can summarise solutions.	
Resources	Resource 25: Action plan	**30**

Activity instructions

Explaining under pressure:

- Ask participants to try and reflect on everything they have learned today or a resource they thought was really useful. You might ask them to close their eyes or think for a moment in silence.
- Ask them to pick one thing that they think is really important from the day.
- Ask them to get into pairs or threes and share what they thought was important – a key point, the headline or something they didn't know before.
- Tell participants to take it in turns to try explaining that one idea (A) and link it to an action someone could take or a way they could get involved (B). For example 'I hadn't heard of Community Controlled Health Organisations (A) – you can get in touch and volunteer with a Community Controlled Health Organisations (B)'. Give them a few minutes to prepare and gather relevant resources.
- Give them 2 minutes (no more) to try and explain their A and B points. Once they have both had a chance to try explaining their key point from the day, ask them to tell each other how they found the experience of sharing this knowledge or information. This can also be done as a whole group activity, or by asking people to volunteer to say how they found it.

Note: by only giving two minutes to explain, it creates a pressure on time. The learning point for this activity is that it **is** difficult to explain but that with practice and the right resources, it can make more sense (see key learning points)

Action planning:

- Ask the groups to work together to complete their own action plan. This could include something they will do, or something they will try to help someone else understand. For example 'I will explain to my group what a PHN is and how they can be involved.
- Ask if anyone would like to share their next action with the group. If appropriate (and agreed before hand) ask anyone from the local organisation to talk briefly about the day and what they hope the next actions will be.

Key learning points

- Getting involved in influencing commissioning can seem complicated, but explaining the basics and some starting points can be very simple.
- By taking the time to explain these ideas to other people, you are helping strengthen public involvement

Resources

Resource 1: A brief history of human rights in healthcare

Date	What was written?
1948	**Universal Declaration of Human Rights** The Universal Declaration essentially is the 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family'. This declaration itself had its roots in the Sankey Committee's 'Declaration of the Rights of Man' of which the principle author was H.G Wells. It states: '**Everyone has the right to a standard of living adequate for the health and well-being** of himself and of his family, including food, clothing, housing and medical care and necessary social services'[11]
1978	**Declaration of Alma Ata** The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care and was adopted by all members of the World Health Organization (WHO). It states: 'The people have **the right and duty to participate individually and collectively in the planning and implementation of their health care**' "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination…. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."[12]
1981	The WHO programme "Health for all" was defined as meaning: 'health is to be brought within reach of everyone in a given country. And by "**health" is meant a personal state of wellbeing**, not just the availability of health services—a state of **health that enables a person to lead a socially and economically productive life**. "Health for all" implies the removal of the obstacles to health—that is to say, the elimination of malnutrition, ignorance, contaminated drinking-water, and unhygienic housing'[13]
2012	**Australian Commission on Safety and Quality in Health Care** The 'Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 2: Partnering with Consumers': '**requires leaders of a health service organisation to implement systems to su**pport partnering with patients, carers and other consumers'[14]

[11] http://web.archive.org/web/20170525071813/http://www.un.org/en/universal-declaration-human-rights/index.html

[12] http://web.archive.org/web/20170607041134/http://www1.paho.org/English/DD/PIN/alma-ata_declaration.htm

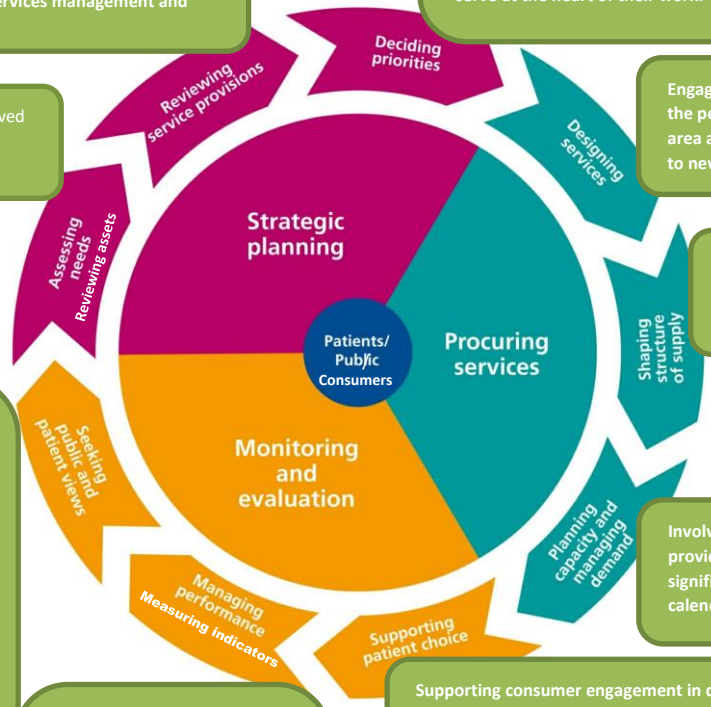
[13] http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2016.106136

[14] https://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard2_Oct_2012_WEB.pdf

Resource 2: Why and how: Involving the public in the commissioning cycle

(next page)

Involving the public in the commissioning cycle



- Public or 'citizens'' panel
- Community researchers
- Participatory or community appraisal and mapping
- Public dialogue, meetings, including simultaneous facilitated online interaction
- Nominal groups and interactive shared learning events
- Surveys and feedback forms (online and offline) and site-specific feedback using interactive technology and

- Surveys and feedback forms (online and offline)
- Real time feedback using technology (e.g. patient trackers or notepads)
- Interviews and storytelling
- Focus groups or deliberative workshops
- Participatory service integration and gap analysis
- Public or citizens' juries

Engaging the public in reviewing service provision provides additional perspectives that complement that of health and community services management and quality officers.

The public have a unique insight into their community and need to be involved in assessing needs, identifying community assets, agreeing priorities and shaping the future of health and community services in the region.

Consumer and community engagement in prioritising services, programs and initiatives is essential because of the finite nature of the resources in primary health care. Deciding priorities through a process of consumer and community engagement will also support seeking funding for primary heath in the region as it will demonstrate that the PHN is putting the needs of the people they serve at the heart of their work.

- Open space or 'unconference'
- Priority Setting Partnerships , deliberative mapping and polling or consensus voting

- Co-production
- Experience-based design
- Participatory Strategic Planning
- Hackathon

Engaging the public in co-design or co-production will ensure that the needs of the people who use health and communities services in the PHN catchment area are responded to. Engagement in co-design or co-production can also lead to new and innovative ideas or models of care.

The public, local communities and consumers will have a unique insight into how services interact within their community. Involving them shaping the supply may lead to innovative delivery methods and new partnerships.

- Public meetings, including simultaneous facilitated online interaction (for example, social media)
- Open Space or 'unconference'

Involving the public in planning and managing demands for services in the region provides a unique insight into what might affect demand on services. In particular, significant population characteristics, diversity in the community, or times of the annual calendar in certain communities might have an impact.

- Open space or 'unconference'
- Surveys and feedback forms (online and offline)
- Open days

Supporting consumer engagement in decision making and embracing a patient-centred care approach to healthcare ensures people receive services and care which is responsive to their needs, preferences and wishes.

- Involving the public in the review and development of health information
- Using decision aids and developing decision aids in collaboration with consumers
- Ward rounds with consumer representatives
- Learning and education opportunities for staff on patient centred care
- Health champions and ambassadors
- Training and resources to establish peer-support (groups, mentors and buddies)
- Members of the public involved in training of health providers and clinicians

Involving the public in the planning, monitoring and evaluation of engagement processes helps ensure the PHN will be responsive to the consumer perspective and resources are allocated effectively. *

Use the following methods to help draft an engagement and involvement strategy:

- Advisory committee or group
- Participatory Strategic Planning
- Survey
- Focus group

Work in partnership to:

- Prototype engagement activity with evaluation
- Finalise the strategy

Inviting the public to provide feedback about service provision is essential to identify areas in need of improvement, quality and safety issues and determining emerging priorities. Involving them in the design and strategy of any feedback tools is also important in ensuring they are useful, understandable and accessible to the community they are targeted at.

- Designing surveys and feedback tools
- Training lay people, patients and consumers to carry out interviews
- Experience-based design
- Involve public in analysing, interpreting and disseminating results

Involving the public in developing and reviewing performance indicators (e.g. complaints and suggestions and compliments systems) can provide a unique perspective into monitoring the delivery of services.

It can also gauge the views the public or other consumers' experience of using services and help to elucidate innovative ways of improving services.

- Formal independent groups with two-way accountability
- Experience-based design
- Mystery shopper
- User panels
- Local issues/area forums

Key

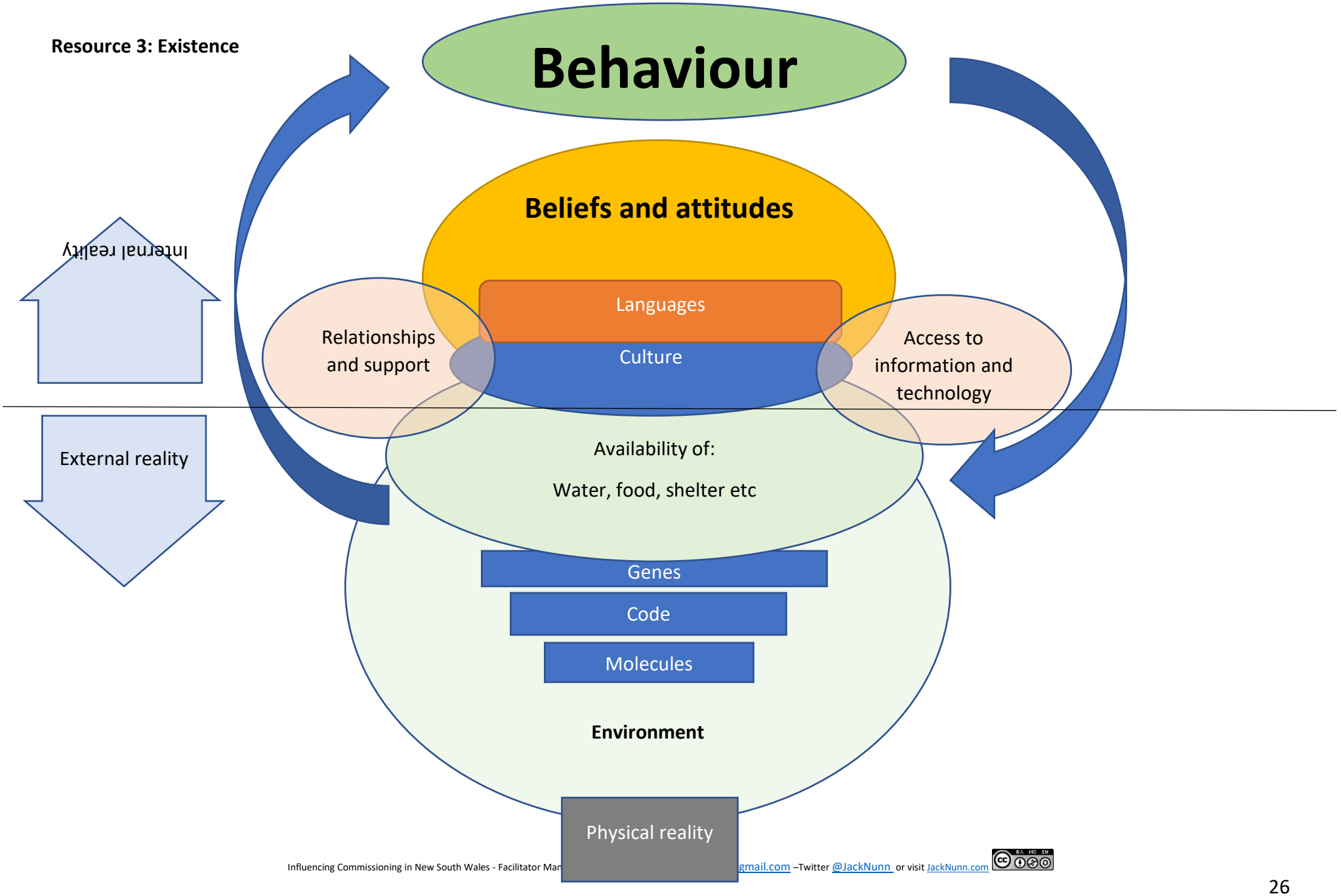
Rationale: Why engaging and involving the public is important

Strategies: Ways of engaging and involving the public and the community

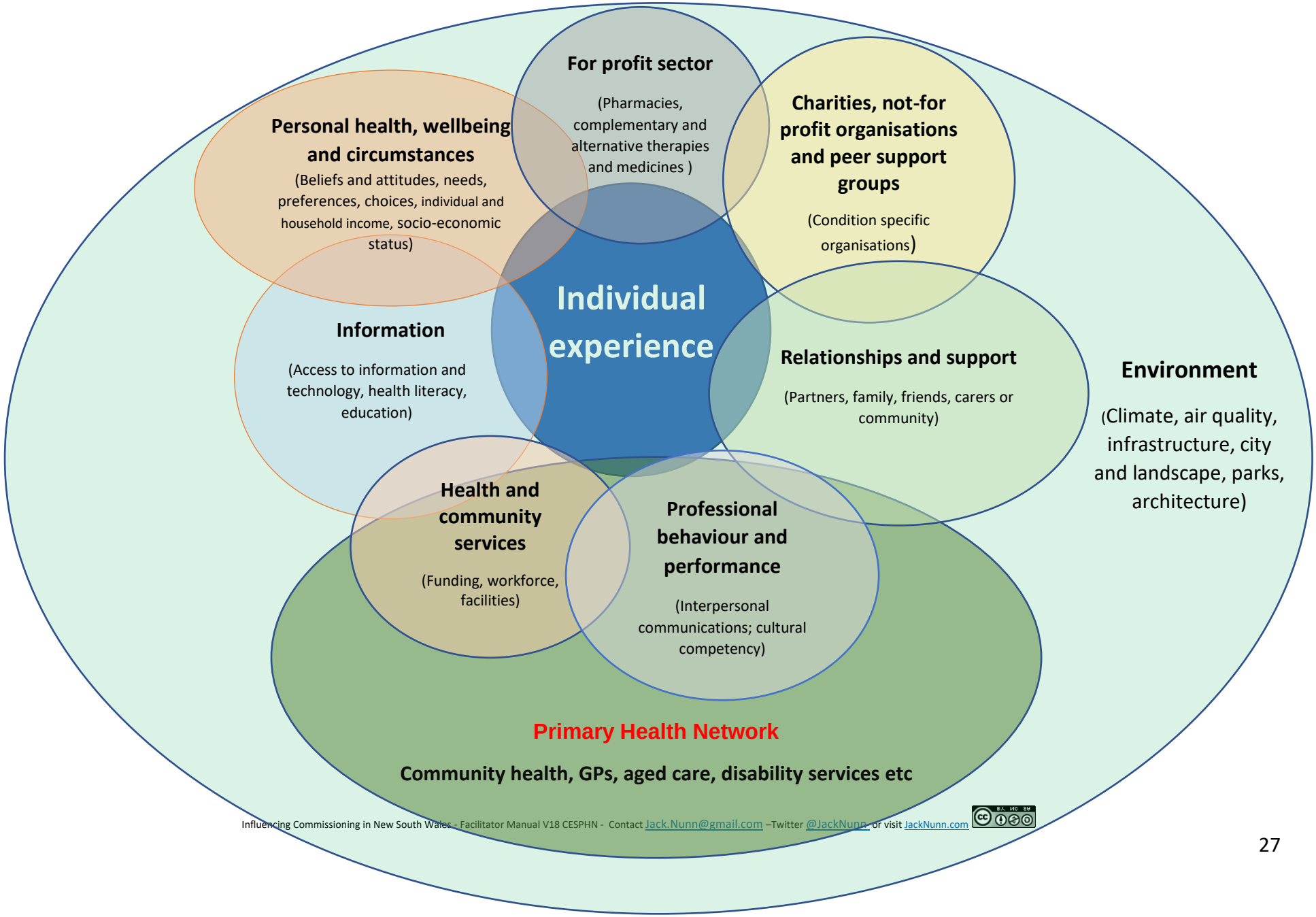
* Start here

ng in N ... om –Twitter @JackNunn or visit JackNunn.com

Resource 3: Existence

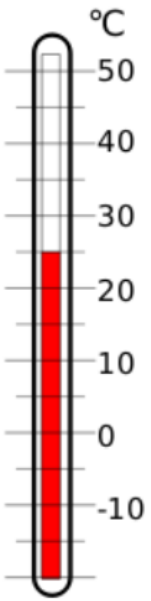


Resource 4: What affects individual experience?



Resource 5: What is data?

Qualitative



Quantitative

Qualitative data is subjective, recording how subjects (e.g people) communicate the qualities of their experience.

Quantitative data is objective, recording how measurable and quantifiable things, objects and people behave and interact.

"How would you describe the temperature" is a question which would gather qualitative data

"What is the temperature in Celsius?" is a question which would gather quantitative data

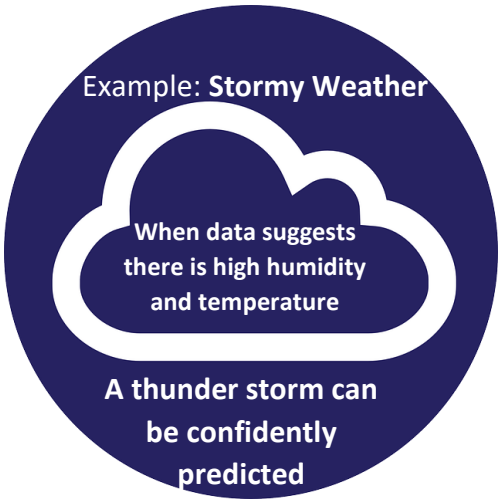
They are both equally important if we want to have a complete and holistic understanding and knowledge.

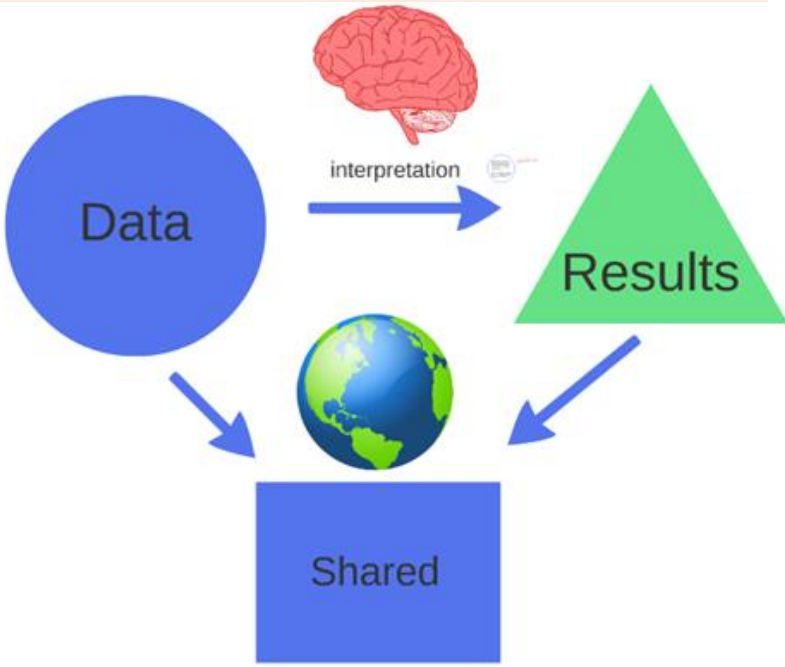
Both these kinds of data are given meaning by the process of interpreting it.

Resource 6: How data becomes evidence that shapes services

All good commissioning decisions rely on using data to be informed. This often involves research.

Interpretation sometimes involves spotting patterns, which makes it possible to make predictions or give explanations.
If the predictions are reliable, this is how interpreting data can provide evidence.
The public can be involved in analysing data used to make commissioning decisions.





If researchers and commissioners share:

- the data itself
- their results
- the method of how they gathered the data

Then other people can:

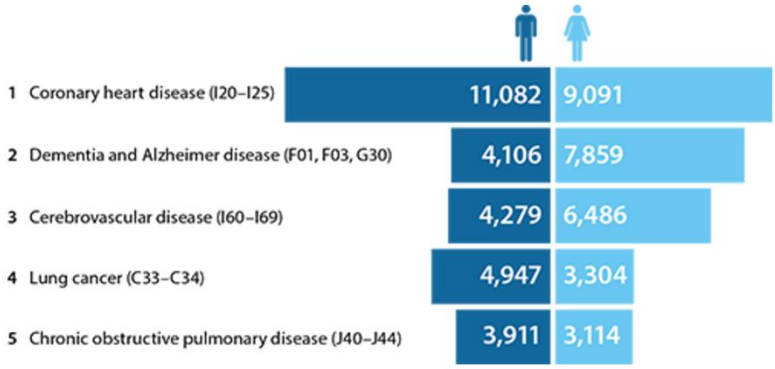
- check they agree the method was appropriate
- interpret the data themselves
- agree or disagree with the results
- Spot new patterns, make additional predictions or give alternative explanations.

The more data there is, often the clearer and more predictable the patterns are, and the data can be said to provide evidence that we can make predictions.

If data and results are shared, researchers can use and build on this knowledge in the future. This process makes researchers more confident when recommending actions.

Resource 7: Leading underlying causes of death in Australia by age group, 2012–2014

	1st	2nd	3rd	4th	5th
Age < 1	Infant/congenital **Perinatal & congenital**	Other **Ill-defined**	Infant/congenital **SIDS**	Injury **Accidental threats to breathing**	Other **Selected metabolic disorders**
Age 1–14	Injury **Land transport accidents**	Infant/congenital **Perinatal & congenital**	Cancer **Brain cancer**	Injury **Accidental drowning & submersion**	Other **Cerebral palsy & related**
Age 15–24	Injury **Suicide**	Injury **Land transport accidents**	Injury **Accidental poisoning**	Injury **Assault**	Injury **Event of undetermined intent**
Age 25–44	Injury **Suicide**	Injury **Accidental poisoning**	Injury **Land transport accidents**	Cardiovascular **Coronary heart disease**	Other **Liver disease**
Age 45–64	Cardiovascular **Coronary heart disease**	Cancer **Lung cancer**	Cancer **Breast cancer**	Injury **Suicide**	Cancer **Colorectal cancer**
Age 65–74	Cancer **Lung cancer**	Cardiovascular **Coronary heart disease**	Respiratory **COPD**	Cardiovascular **Cerebrovascular disease**	Cancer **Colorectal cancer**
Age 75–84	Cardiovascular **Coronary heart disease**	Cardiovascular **Cerebrovascular disease**	Mental/neurological **Dementia & Alzheimer disease**	Cancer **Lung cancer**	Respiratory **COPD**
Age 85–94	Cardiovascular **Coronary heart disease**	Mental/neurological **Dementia & Alzheimer disease**	Cardiovascular **Cerebrovascular disease**	Respiratory **COPD**	Cardiovascular **Heart failure**
Age 95+	Circulatory **Coronary heart disease**	Mental/neurological **Dementia & Alzheimer disease**	Cardiovascular **Cerebrovascular disease**	Cardiovascular **Heart failure**	Respiratory **Influenza & pneumonia**

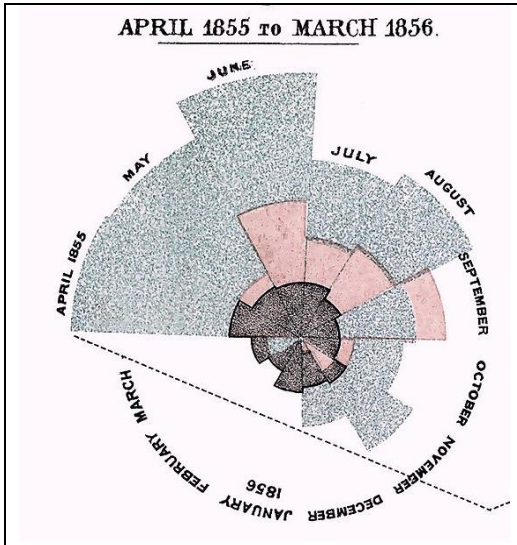


These infographics were taken from the Australian Institute of Health and Welfare.[15]

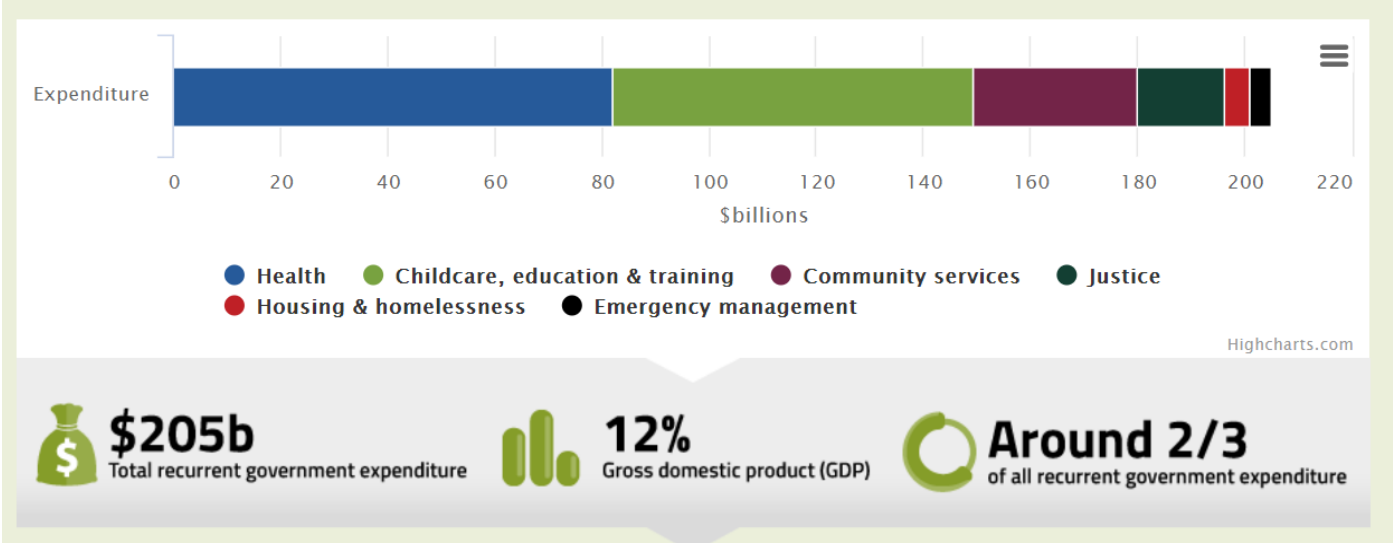
[15] http://web.archive.org/web/20170606032009/http://www.aihw.gov.au/deaths/leading-causes-of-death/

Resource 8: Data – understanding and visualisation

Florence Nightingale is world famous, but not as well known is that she was a statistician and created graphical data to tell story and save lives.[16] Her diagram below shows in blue the preventable deaths at different times of the year. Explaining data in ways that people can understand saves lives. Sir Arthur C Clarke said that communication 'is both an art and a science'.[17]



This diagram was used by Florence Nightingale to help petition Queen Victoria to improve care for soldiers – the large blue areas show preventable deaths according to calendar months.



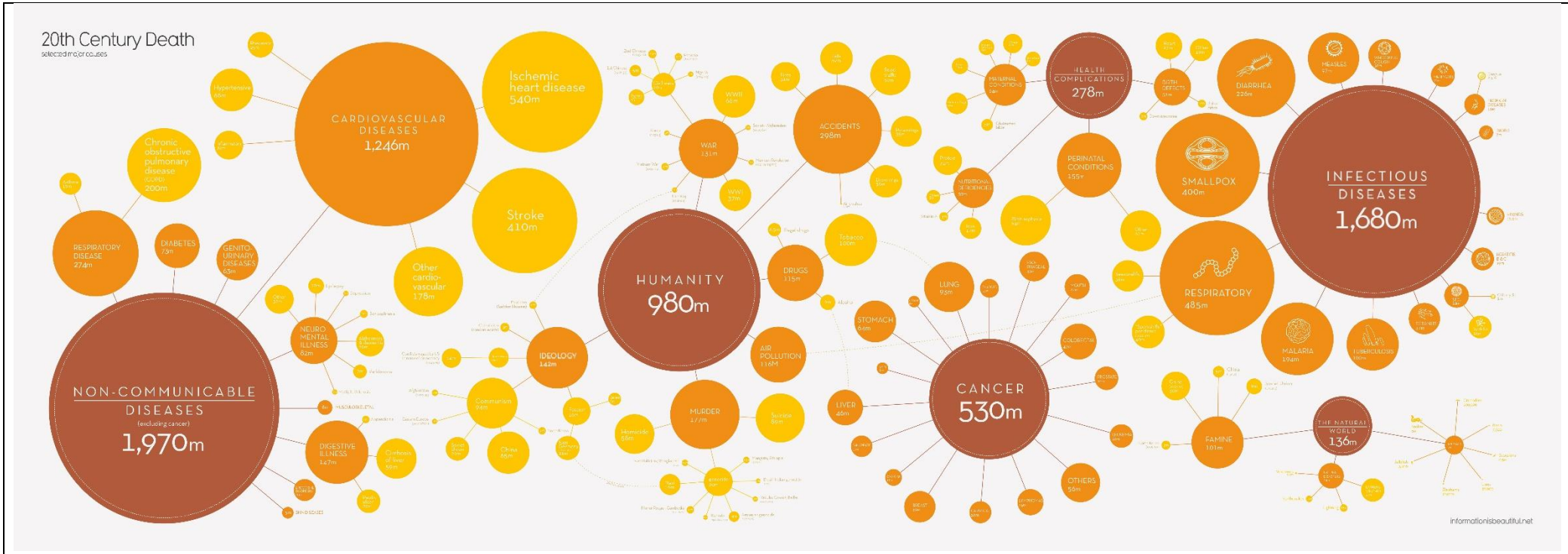
The Australian annual Report on Government Services (RoGS) provides information on the equity, effectiveness and efficiency of government services in Australia.[18]

Visualising data is considered an effective way of communicating complex information.

[16] https://en.wikipedia.org/wiki/Florence_Nightingale#/media/File:Nightingale-mortality.jpg

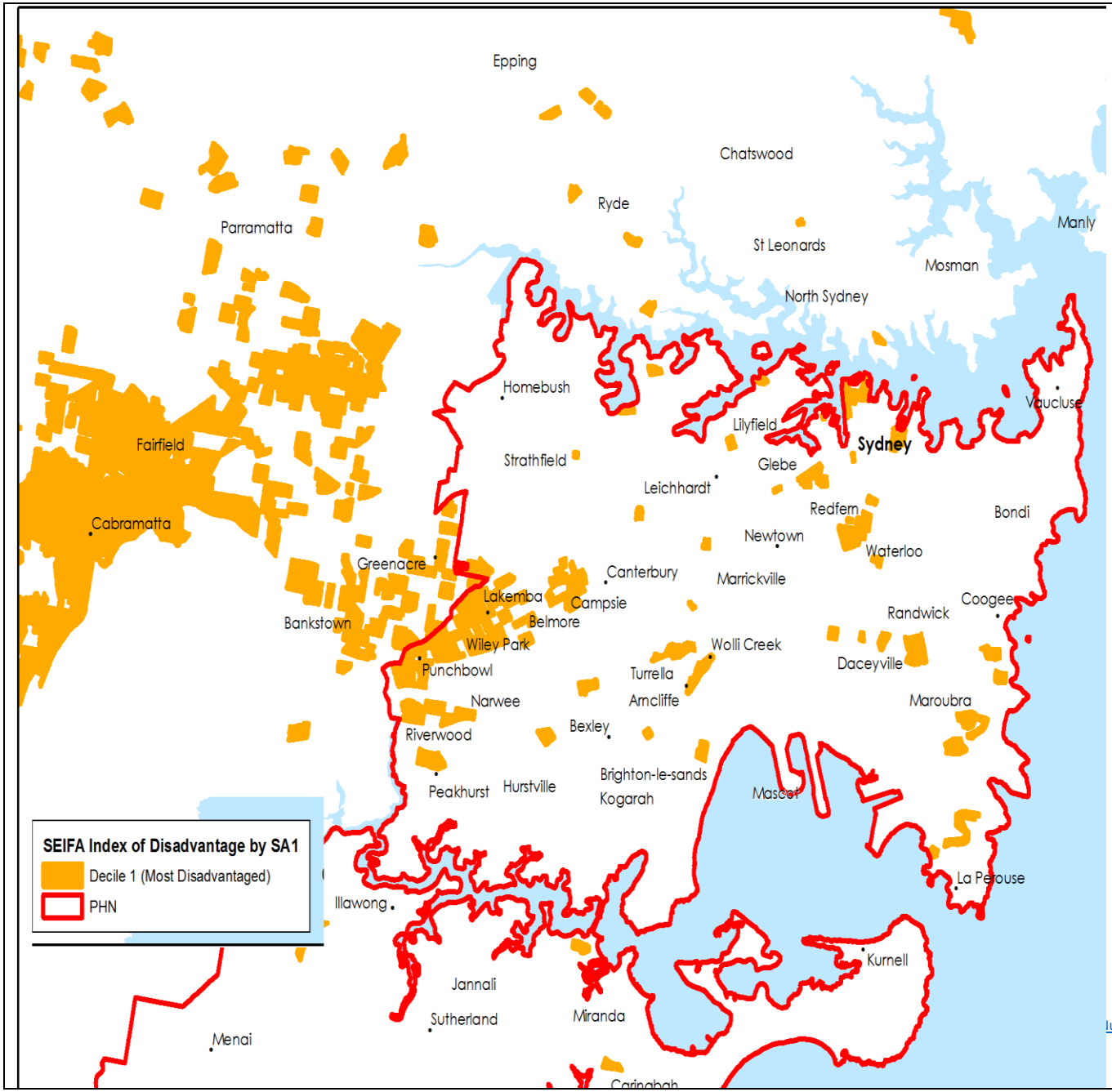
[17] http://web.archive.org/web/20170606030805/http://www.asia-pacific.undp.org/content/rbap/en/home/library/climate-and-disaster-resilience/communicating-disasters-resource-book.html

[18] http://web.archive.org/web/20170606030443/http://www.pc.gov.au/research/ongoing/report-on-government-services



This diagram from 'Information is beautiful' shows what killed people in the 20th century – the size of the bubbles indicating the number of people killed.[19]

[19] http://www.informationisbeautiful.net/visualizations/20th-century-death/

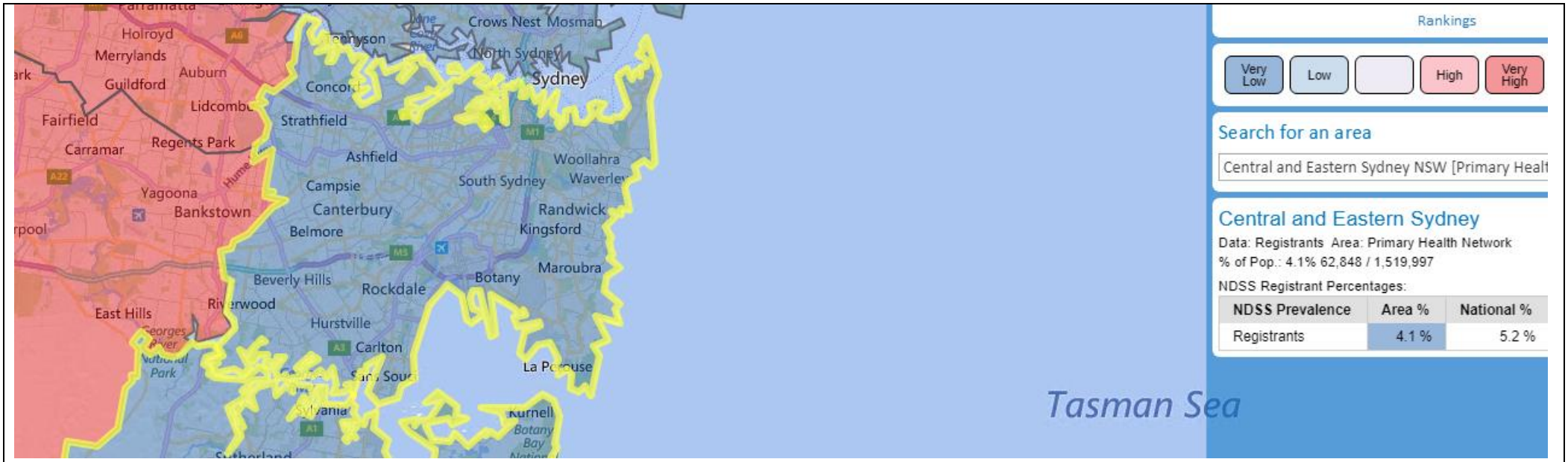


Areas of Socioeconomic Disadvantage (SEIFA)

Please note this image is cropped but that there are no areas of disadvantage outside the cropped area.

Taken from:
http://www.health.gov.au/internet/main/publishing.nsf/Content/503C7D0F1A39C1D5CA257F1500041405/$File/PHN_101_SEIFA_2.png

lunn or visit JackNunn.com



Data taken from http://www.diabetesmap.com.au/#/

Resource 9: Recurrent health expenditure, by source of funds and area of expenditure, 2013-14

Consider: What is interesting about this? What could be improved about the presentation?

		Government						Non-government				
		Australian Government										
Area of expenditure	*Unit*	*DVA*	*Health and other*	*Health insurance premium rebates* (e)	*Total*	*State, Territory and local*	*Total government*	*Private health insurance funds*	*Individuals*	*Other* (f)	*Total non-government*	*Total*
Expenditure												
Hospitals	$m	1 673	15 983	3 128	20 784	25 295	46 079	7 289	2 752	2 651	12 691	58 771
Public hospital services (g)	$m	759	15 677	405	16 841	24 788	41 629	944	1 308	1 842	4 094	45 723
Private hospitals	$m	914	306	2 723	3 943	507	4 450	6 344	1 444	809	8 598	13 048
Primary health care	$m	1 628	20 708	997	23 334	7 692	31 026	2 323	19 358	2 023	23 704	54 730
Unreferred medical services	$m	857	7 837	..	8 694	..	8 694	..	686	1 217	1 903	10 597
Dental services	$m	109	503	664	1 275	713	1 989	1 547	5 336	43	6 925	8 914
Other health practitioners	$m	256	1 253	312	1 822	9	1 831	726	2 490	372	3 589	5 420
Community health and other (h)	$m	1	1 252	–	1 253	6 155	7 408	1	224	185	409	7 817
Public health	$m	..	1 251	..	1 251	815	2 066	..	26	128	153	2 220
Benefit-paid pharmaceuticals	$m	406	8 047	..	8 452	..	8 452	..	1 598	..	1 598	10 050
All other medications	$m	..	566	21	587	..	587	49	8 999	78	9 126	9 713
Other	$m	212	17 695	1 401	19 308	3 362	22 670	3 265	5 622	461	9 348	32 018
Patient transport services	$m	169	57	78	304	2 196	2 500	183	402	104	689	3 188
Referred medical services	$m	..	11 593	589	12 182	..	12 182	1 374	2 584	..	3 958	16 140
Aids and appliances	$m	2	458	247	707	..	707	575	2 627	77	3 280	3 987
Administration	$m	38	1 349	487	1 873	348	2 221	1 134	4	1	1 138	3 360
Research	$m	2	4 240	..	4 242	818	5 060	..	5	278	283	5 343
Total recurrent funding	**$m**	**3 513**	**54 386**	**5 526**	**63 426**	**36 349**	**99 775**	**12 877**	**27 732**	**5 135**	**45 743**	**145 519**

Source: http://web.archive.org/web/20170606024721/http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/health/rogs-2016-volumee-sectore.pdf

Resource 10: Patient Experience Survey 2013-14 (selected results)

Proportion of people who reported excellent, very good or good health in the last 12 months

PHN Name	PROPORTION %	RELATIVE STANDARD ERROR OF PROPORTION %	CONFIDENCE INTERVAL WIDTH %
Central and Eastern Sydney	86.936	1.556	5.302

Proportion of people who needed to see a medical specialist but didn't at least once in last 12 months

PHN Name	PROPORTION %	RELATIVE STANDARD ERROR OF PROPORTION %	CONFIDENCE INTERVAL WIDTH %
Central and Eastern Sydney	10.526	15.141	6.247

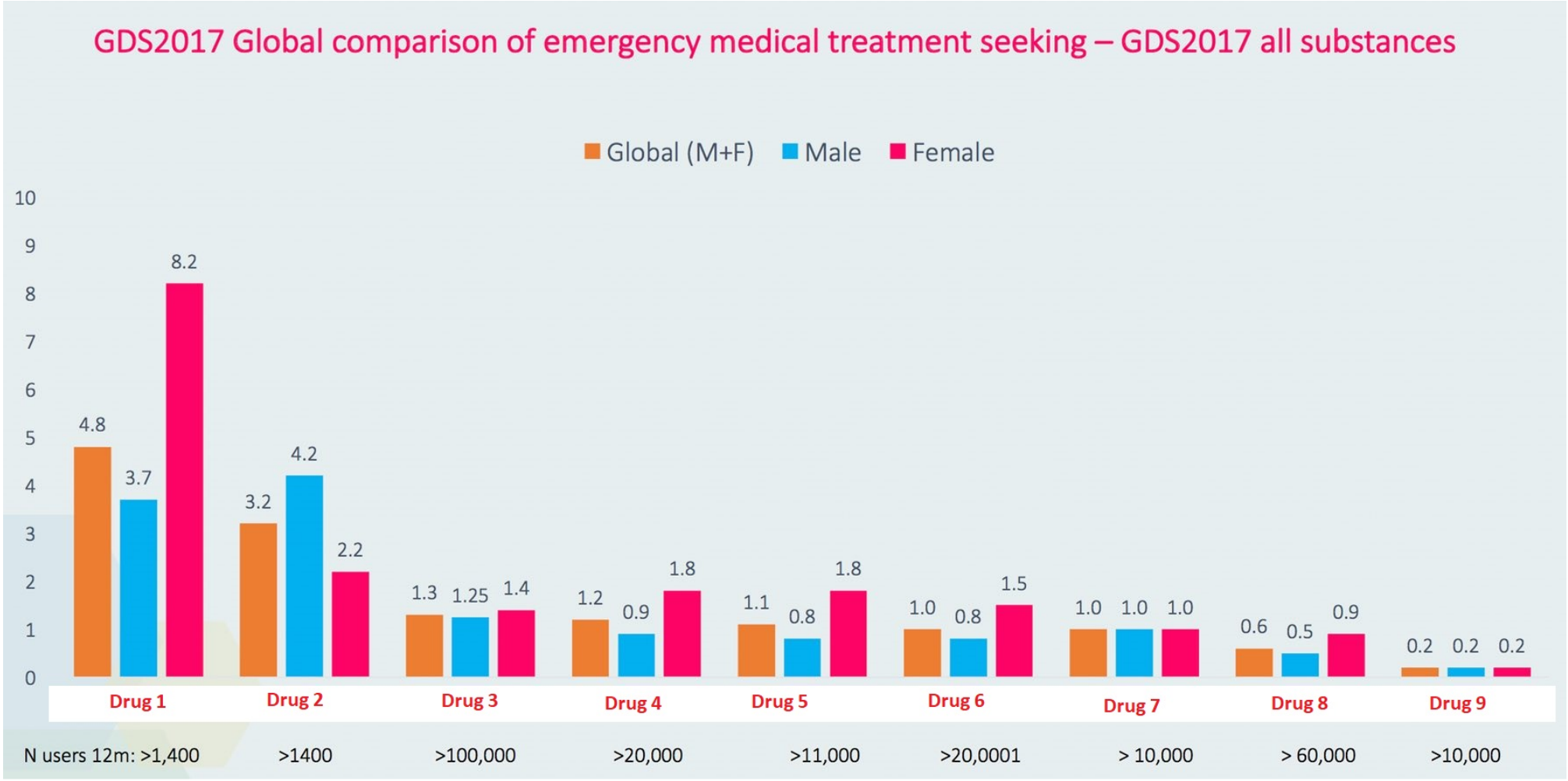
PHN Name	PROPORTION %	RELATIVE STANDARD ERROR OF PROPORTION %	CONFIDENCE INTERVAL WIDTH %
Central and Eastern Sydney	4.799	19.224	3.616

Proportion of people who needed to see a GP after hours but didn't in the last 12 months

PHN Name	PROPORTION %	RELATIVE STANDARD ERROR OF PROPORTION %	CONFIDENCE INTERVAL WIDTH %
Central and Eastern Sydney	31.196	14.602	17.856

Resource 11: Data - Perceptions and reality – matching drugs with deaths

A recent study by the Global Drug Survey analysed which drugs were responsible for the most emergency medical treatment[20]. Australians made up nearly 5% of respondents. **Match the following drugs to the numbers** and see which ones you would consider commissioning interventions for – which would they be? Alcohol, Amphetamine, Methamphetamine, Cannabis, Synthetic Cannabis, LSD, Magic mushrooms, MDMA/Ecstacy, Cocaine.



Resource 12: Statistics – state data and community data

The history of statistics is rooted in 'statecraft' – the science of attempting to understand what is happening in a country, for example, a census. Statistics deals with all aspects of data including the planning of data collection and analysis. Traditionally both gathering and analysing has been difficult and expensive. However, with the advent of cheap computers – gathering, sharing and analysing this data is now easier for more people. Try and solve a problem using data gathering, sharing, analysis and communication:

What is your problem? Who is affected?

Data gathering **What is your data?** **How would you gather this data?** **Who is involved in gathering it?**	**Data sharing** **Who would you share the data with?** **Who shouldn't be able to access it?** **How would you share it?**	**Data analysis** **Who would be involved in analysis?** **Who would be excluded? Why?** **How could you support people to be involved in analysis?**	**Communication and translation** **Who would you share your analysis with? How?**

- What is your intervention? What are the **OUTPUTS**?
- What outcomes are you measuring? Why? Who is measuring them and how?
- What **EXPERIENCES** might you want captured?
- Think about the ways in which these experiences and needs be **communicated** to the right people….

Resource 13: Language to describe commissioning

Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.[21]

Australian Government:

> "a strategic approach to purchasing that seeks to ensure that services meet the health needs of the population and contribute towards service and system improvement and innovation"[22]

Definition from CESPHN:

> "Commissioning is a continual and repeating cycle involving the development and implementation of services based on planning, procurement, monitoring and evaluation. Commissioning describes a broad set of linked activities, including needs assessment, priority setting, service design and procurement through contracts, monitoring of service delivery, and evaluation and review."[23]

Cut out and match these terms[24] to the definitions:

Term	Definition
Joint commissioning	concerned with the ways in which relevant organisations might work together and with their communities to make the best use of limited resources in the design and delivery of services and improve outcomes.
Decommissioning	The planned process of removing, reducing or replacing health care services. There are circumstances, for example, where services are inefficient or ineffective, or where there are changes in the environment, funding or CESPHN's priorities and we may need to end or reduce services or end a contract.
Procurement	the activities and processes undertaken to acquire goods and services.
Block contract commissioning	describes a commissioning approach where a tender recipient is given a block of funds to achieve a particular objective.
Activity commissioning	tied to specific health activities and funding is provided based on the number of services or activities provided.
Outcome commissioning	ties funding to achievement of a stated outcome. This approach does not involve CESPHN specifying how to achieve an objective. Providers have autonomy to design the activity that achieves the outcome.

21 https://www.cesphn.org.au/documents/hierarchical-document-list/communications-1/1084-commissioning-framework-2016-2018

22 https://www.cesphn.org.au/documents/hierarchical-document-list/communications-1/1084-commissioning-framework-2016-2018

23 https://www.cesphn.org.au/health-services/commissioning

24 https://www.cesphn.org.au/...list/...1/1084-commissioning-framework-2016-2018

Resource 14: The commissioning cycle

Taken from the report: https://www.cesphn.org.au/documents/hierarchical-document-list/communications-1/1084-commissioning-framework-2016-2018

Resource 15: Levels of involvement

Involvement can happen at a number of levels. While each one impacts on the public and PHNs can only influence certain levels, each level provides and opportunity for sharing learning and best-practice can be relevant.

1. **Individual or personal care level** – where the individual and their relevant others are engaged, active, and informed participants in the decision making processes about their own health care and treatments.
2. **Service (provision) level** – where the public, consumers and communities are engaged in the decision making processes about how services are planned, designed, delivered and evaluated.
3. **Local (integration) level** - where the public, consumers and communities are engaged in the decision making process that the PHN embarks on in fulfilling its role; this includes governance of the PHN and the Community Advisory Committee and ensuring engagement activity is co-ordinated across the area.

While the following levels are 'above' the PHN level, the following levels are still relevant, particularly when looking at sharing learning and best practice in engagement and creating partnerships to support engagement.

4. **State level** – where the public, consumers and communities are engaged in decision making processes at state level, where systemic changes or innovations may affect the PHN's work and goals. This includes public, consumer or community representatives representing the interests of the community and the PHN at state level forums and engaging with other consumers and community representatives across Victoria. This level also provides an opportunity to ensure engagement activity is co-ordinated across the state.
5. **National level** – where the public, consumers and communities are engaged in decision making processes at national (Federal Government) level, where systemic changes or innovations may affect the PHN's work and goals. This includes consumer or community representatives representing the interests of the PHN at Australia-wide forums and engaging with other consumers and community representatives from across Australia. This level also provides an opportunity to ensure relevant learning and best-practice in engagement is shared nationwide.
6. **International** – where the public, consumers and communities engaged with the PHN as consumer representatives or members of the Community Advisory Committee can be strengthened by international collaboration and sharing. This level also provides an opportunity to ensure relevant learning and best-practice in engagement is shared internationally.

Resource 16: What Are You Doing To Involve People?

How are the public involved in your work? This is an action-based approach to the spectrum of involvement, designed to aid discussion about **assessing current involvement and planning for future activities.** The pyramid gives an indication of how many people might be involved in each action.

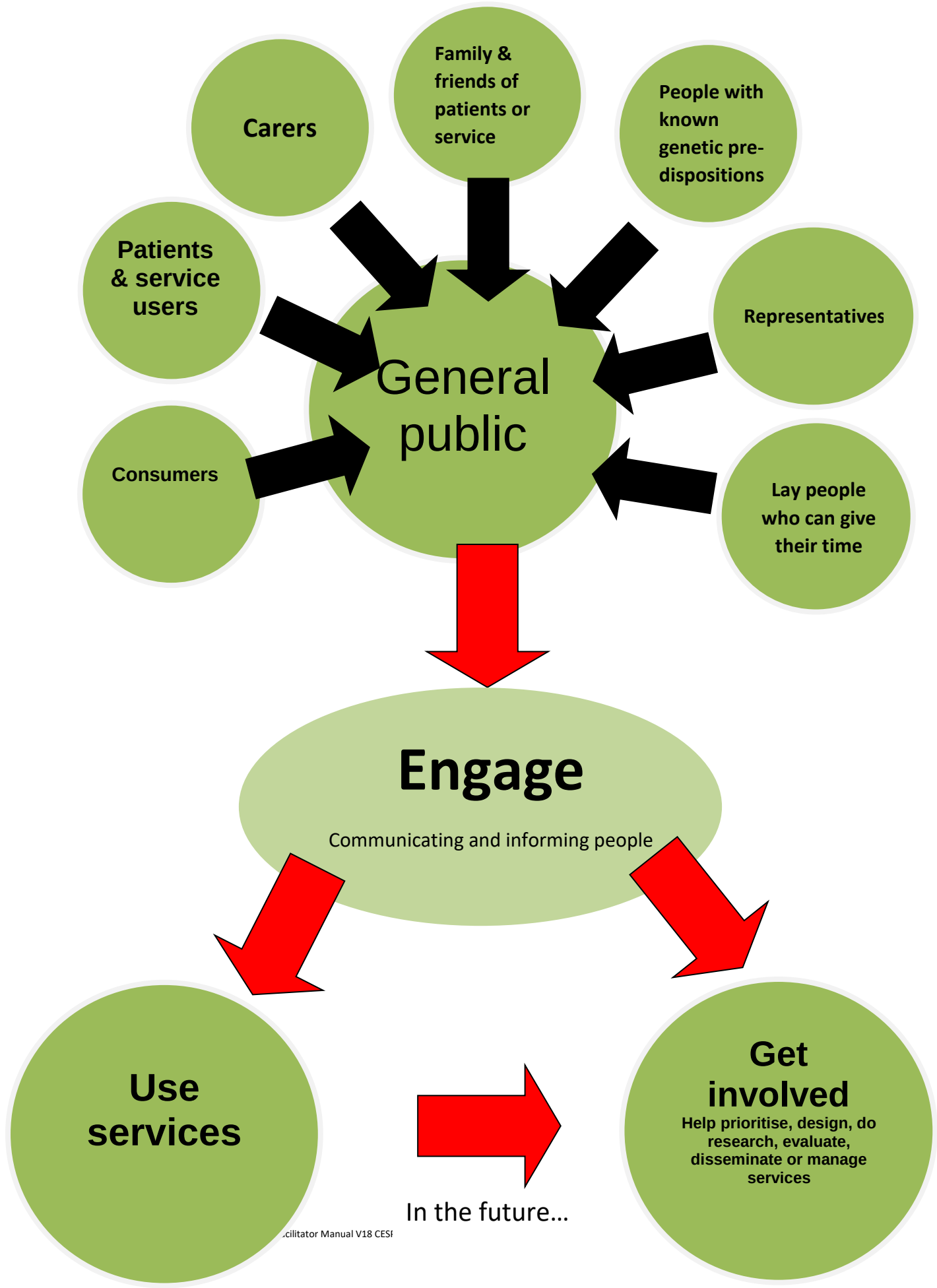
Actions	Involve people by…
Innovating This includes prototyping, piloting, establishing and creating new ways of doing things. This can include anything from building partnerships or buildings.	**Supporting them to:** • Design and carry out research • Create solutions • Implement ideas • Learn from actions
Managing, delivering and evaluating Working in partnership to manage ongoing activities.	**Having:** • Clear roles and tasks for the public • Elections and interviews when appropriate • Clear and accessible accountabilities for all roles (including staff), groups and committees. **Asking them to take actions such as:** • Managing or overseeing actions, processes and procurement • Directly delivering services or reviewing providers • Evaluating actions, processes and outcomes
Prioritising and planning Working in partnership to prioritise actions and plan implementation.	• Agreeing priorities in a clear, transparent way (this can include stopping certain actions) • Having clear accountabilities for planning at all stages • Having a transparent and adaptable budget
Listening, responding and acting Actively seeking feedback, responding to ideas, compliments and complaints with actions.	**Asking them to help:** • Interpret feedback • Influence responses to ideas, compliments and complaints • Asking for ideas for actions This includes telling people what this action was, particularly those who have given feedback.
Asking and discussing Asking people what they think, need and want and discussing it with them.	Inviting people from your intended audience or people you are trying to help to: • Design **how** you will collect feedback and **interpret** the results • Identify any potential barriers that might stop people from giving feedback.
Telling Giving information about what you have done, are doing or are going to do.	• Sharing opportunities to be involved • Asking people for ideas and support to share and disseminate what you want to tell people • Ask for feedback about how you are sharing information and attempt to measure the impact.

Resource 17: Assessing: how are the public involved?

Fill in this grid to assess what you are already doing to involve people and plan new ways

Action	How are people already involved?	How could people be involved?	What support might they need
Innovating			
Managing, delivering and evaluating			
Prioritising and planning			
Listening, responding and acting			
Asking and discussing			
Telling			

Resource 18: Diagram of engagement, participation and involvement in commissioning



Resource 19: Answering important questions using Maslow's 'hierarchy of needs'

Maslow's hierarchy claims that needs that are **low** in the hierarchy must be partially satisfied before needs that are **high** in the hierarchy can be prioritised. Think of a hierarchy as a pyramid, 'low' meaning a basic foundation.

The answers to the questions on the left lie at the very heart of good meetings. They've been placed in an order to approximate to the hierarchy. Discuss whether you agree with the questions being placed with the associated needs?

1. Will this be a good use of my time? 2. Why are we meeting anyway? 3. Are we going to accomplish something? Will this meeting help me make a difference?	**Self Actualisation** To find self fulfilment and realise one's potential
4. Will we stay on the topic or go off at a tangent?	**Creative needs** To create symmetry, order, and beauty
5. Is there an agenda?	**Cognitive needs** To know, learn explore, find out
6. What's expected of me? 7. What happened as a result of the last meeting? 8. Will we be making decisions and if so how?	**Esteem needs** To achieve, to be competent, gain approval and recognition, self-confidence, independence
9. Should I be here? Am I welcome? Do I feel I am being treated with respect?	**Belongingness and love** To be loved, liked needed or accepted by others
10. Where are the fire escapes? 11. Who are the other people?	**Safety needs** To be free of danger physically and emotionally – a sense of security
12. When will we take a break (e.g. to go to the toilet)? 13. Where is the food? When will we eat? 14. How long will this take? When are we leaving? (Will I need a strong coffee or a sleeping bag?)	**Physiological needs** Food, water, shelter, sleep, excretion

High

low (basic)

Questions adapted from Roberta's Rules of Order by Alice Collier Cochran Published by 2004.

Resource 20: Patient, consumer and public involvement

There are many things to think about when involving the public and patients in improving services – this document is intended to help ask the right questions for the right roles.

How to use this resource: Under 'Assumptions and barriers', read the questions and consider if these might be barriers to involving some people, and consider how you might overcome these. 'Learning needs and support' examines the role in more detail and asks questions about the support people might need to help them develop.

Be clear what you want– do you want 'patient', 'user' or 'carer' involvement, a lay perspective or just anyone who can give their time? Consider who you might unintentionally exclude by using these terms and be clear what you mean by *engagement* or *involvement.*

Assumptions and barriers	Role Description	Learning needs & support
• What commitment do you expect (time/financial implications) • Have you asked people to think about their emotional readiness? • Do you expect them to be reading and writing information and documents? Have you considered what formats might be appropriate? • Are you assuming a good ability to speak and read English? • Do you expect a certain educational background?	**Consumer/Lay Leader:** A person who speaks and acts on behalf of all members of the public, including patients and carers and who takes a leading role in representing other lay representatives. The role may involve holding people or organisations to account. **Consumer/Lay representative:** a member of the public (not a professional) who is a representative. They must speak and act on behalf of others. They may be guided by lay leaders but will be expected to take direct action to ensure that they are informed and able to represent the views of others.	**How are they supported to be a representative?** • How will they be gathering views? • Will this involve research? • Do they have a budget? • Should they be paid? • Is there admin and practical support (from an organisation?) • Is there any training available? **Who is already doing this?** • Are there any opportunities for them to be involved in peer support or have or be a buddy? • What can be shared with other organisations? (E.g. learning, resources) **How are people involved?** • Can people be involved in other ways? (e.g. is it face to face meetings? What can be done online, what cannot?)
• Are the people who have engaged with you the only people who might be interested?	**Interested and engaged consumers or members of the public:** People who know about and/or are interested in decisions being made, but may take no direct action other than giving feedback, being involved in a public dialogue or signing petitions.	**Could there be a need for translation?** • Are there any groups or organisations who could support with this? **Remember**: 'public dialogue' is not fully 'representative' but can give a strong indication of how the public at large feels
• It is easy to assume that people who are not engaged don't want to be. • Often they won't even know how they can contribute or be involved • Some may not be able to afford the time, caring responsibilities or travel.	**Uninformed, disengaged or disinterested members of the public:** people who, for what ever reason, are not engaged, informed or interested in influencing decision making or shaping the future of health and social services.	**A majority of the population are in this category**. • What information or support might some people need to help engage them or move them into other roles? • What might make people move back into this role? (e.g. not seeing direct improvements, or too much of organisational change?)

Remember: roles are not always fixed, they are often just a way of articulating different things people can or should do. Tasks can be more focused. There is always a way for dedicated people to give their time and develop their skills, what ever the label or role description

Resource 21: Who's who?

Who is involved in influencing health and social care in your local area? Which organisations or groups are missing from this grid?

Federal Government	State Government	Community or not for profit	Private	Other
Federal Department of Health	State Department of Health	Community Controlled Health Organisations	Insurance companies	
Medicare Australia	Public hospitals	Health Consumers NSW	Private hospitals	
Therapeutic Goods Administration	Healthdirect			
Pharmaceutical Benefits Scheme				
Australian Institute of Health and Welfare				

Resource 22: Who I met

Who I met (Name)	Contact details	What I want to talk to them about

Resource 23: 26 Billion dollars

OP 513
1000000000
ONE BILLION DOLLARS
Australia
Lest We Forget
This Australian Note is NOT Legal Tender Throughout Australia And Its Territories

OP 513
1000000000
ONE BILLION DOLLARS
Lest We Forget

Resource 24: You decide: Scenarios

You are asked to complete a Patient Experience Survey by the Australian Bureau of statistics	You are keen to help co-design a service with the professionals to look at chronic illness support
The Primary Health Network wants to design a plan for involving people for a new service	A local service wants an on going panel to give advice on measuring user experience
You want to raise the profile and understanding of your condition	A local charity is interested in becoming a service provider
You are part of a group of people who have an idea about new local service	You are keen to promote access to research opportunities
You want to develop a learning intervention to support young people to make informed decisions about using drugs	You have been asked to make some cuts to spending in maternity services

Resource 25: Action plan

ACTION PLAN

Handout

What I would like to achieve is...

The next action I should take to achieve this is...

The result of this action might be...

Some other actions I can take to achieve this are...

I can get support from...

Some challenges I might face could be...

I could overcome these barriers by...

By this date _____ I will have...

Fill out swap sheet, tear out and hand to your facilitator

Action plan swap sheet

Name _____

Contact me by phone or email or post:

_____

_____

By this date I will have...

Resource 26: Skills and knowledge grid

Knowledge is information you have in your head; a skill is the ability to use knowledge to achieve something.

Skills	Knowledge
Skills I already have (for example driving, speaking English)	**Knowledge I already have** (for example a knowledge of my community or local information resources)
Skills I have that I would like to develop (for example reading academic papers)	**Knowledge I would like to develop** (for example an understanding of reliable sources of evidence)
Skills I don't have but might need (for example using the internet to communicate)	**Knowledge I might need** (for example a knowledge of funding opportunities)
Skills I would be confident in helping others learn (for example, reviewing funding applications)	**Knowledge I would be confident in sharing with others** (for example, a good route for a bike ride)

Resource 27: Feedback Form

Why are we asking these questions?
The information collected will assist us in identifying how effective the learning event was in meeting participants' needs and help us to improve the learning events we offer. Any information you provide will be treated and held in accordance with appropriate data protection law.

Date:

Organisation/location:

Name:

Facilitator: Jack Nunn

Q1. Where did you hear about this event?

Q2. Please describe the area/s of the event that you found most valuable/most enjoyable:

Q3. Please describe the area/s of the event that you found least valuable/least enjoyable and/or areas that could have been developed further:

Q4. How do you intend to apply what you learnt on the event? What will you do differently? What do you think will be the effect of this?

Q5. What recommendations would you like to make for future events?

Please tick the relevant box to show whether you agree or disagree with the following statements.

Statement	**Strongly agree**	**Agree**	**Don't know**	**Disagree**	**Strongly disagree**
Did you feel that the event was useful?					
Did you feel that any learning needs you identified when registering were met?					
The learning resources used helped me to learn					
The trainer facilitator(s) were sufficiently knowledgeable about the subject					
The facilitator(s) used a range of activities to appeal to different learning styles					
The event was structured and paced well					
The facilitator(s) made the subject interesting and enjoyable					
The group of learners was managed well by the facilitator(s)					
I found the opportunity to learn and share with other people useful					
I learned what I expected to learn on this event					
I would recommend this event to others					
I was satisfied with the information and administrative support I received prior to the event					
The venue and refreshments were satisfactory					

Overall, I would rate this event as…(circle)	Excellent	Good	Average	Poor	Very poor

If you have any other comments or suggestions then please write them here or attach them:

Health Consumers NSW may wish to follow up with you within a few months' time in order to understand whether this event helped you in the longer term and if so, in what ways. This may mean completing another short survey by telephone or online. If you would be willing to be re-contacted for this, please provide your contact details below, indicating your preferred method of contact:

Email address/Telephone:

Additional resources

All the resources below are hyperlinks to relevant online resources.

Resource 28: Effect of early, brief computerized interventions on risky alcohol and cannabis use among young people

Resource 29: 12-step programs for reducing illicit drug use

Resource 30: Patient Experience Survey 2013-14

Resource 31: PHN Snapshot

Resource 32: Patient Experiences in Australia: Summary of Findings, 2015-16

Resource 33: Commissioning Mental Health Services - A Practical Guide to Co-Design [p13]

Resource 34: Recommissioning community mental health support services and alcohol and other drugs treatment services in Victoria: Report on findings from interviews with senior personnel from both sectors [p13-15]

Resource 33: commissioning cycle

(next pages)

Assessing needs and reviewing assets

(strategic planning)

Reviewing service provisions

(strategic planning)

Deciding priorities

(strategic planning)

Designing services

(procuring services)

Shaping structure of supply

(procuring services)

Planning capacity and managing demand

(procuring services)

Supporting individual choice

(monitoring and evaluation)

Managing performance and measuring indicators

(monitoring and evaluation)

Seeking public views

(monitoring and evaluation)

Promotion

Flyer

Title: Influencing Commissioning

Subtitle: Have you ever wondered how the public can be involved in shaping the future of health services?

Summary: Influencing Commissioning is a **free event** for anyone who has an interest in how services are planned and paid for and how the public can be involved in these decisions.

You'll leave knowing how the public can influence how funding is spent, how services are designed and how you can improve existing ones.

When and where: insert

If you can make it in person, we'll provide lunch. If you can't make it, we'll be live streaming the event here [link to a page about live stream and social media hashtags].

Register for the free event here or email [insert] [phone?]

Questions for registration form

- Name *
- What would you like to learn?
- How do you think you might use or apply this learning? (allows impact assessment down the line)
- **What motivated you to apply for this learning opportunity?**
- Do you consider yourself to have a disability or any other condition which may affect your ability to participate in the training? [yes/no] If yes, please tell us how we can support you to participate in this training
- Do you have any preferences or allergies that you'd like the people organising the food to know about?
- What is the best way to contact you?
    - Telephone number
    - Email
- Do you require any assistance with travel costs? [link to any info/forms for claiming]

Submit

Please note this form is a way of registering your interest in attending. Places are limited and are given on a first come first serve basis. If you have been given a place, you will receive confirmation with further information.

Feedback

This is the end of the document. If you have any questions, suggestions, comments or feedback please contact Jack Nunn at Jack.Nunn@gmail.com, Twitter @JackNunn or visit JackNunn.com.

This manual was created on Friday, 23 June 2017.